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February 16, 2017

TESTIMONY OF SHELDON TOUBMAN BEFORE THE APPROPRIATIONS COMMITTEE CONCERNING THE GOVERNOR'S PROPOSED CUTS TO THE DSS BUDGET AND CREATION OF AN OFFICE OF HEALTH STRATEGY

Good evening, Senators Osten and Formica, Representative Walker and Members of the Appropriations Committee:

My name is Sheldon Toubman and I am an attorney with New Haven Legal Assistance Association. I am here to testify in opposition to specific proposed cuts affecting the Medicaid program in the Governor's budget for the Department of Social Services, but also in support of maintaining the staffing levels at DSS so as to comply with federal law requirements and to express concern that the proposed new Office of Healthcare Strategy not be given authority to decide how Connecticut should address any reduced Medicaid funding and increased "flexibility" coming from the federal government.

First, the problematic proposed cuts:

Proposal to eliminate Medicaid coverage for 9,500 very low income parents under HUSKY A (Section 11 of HB 7040)

The Governor proposes to reduce HUSKY A eligibility for parents of low income children from 155% of FPL to 138% of FPL, cutting off about 9,500 low income parents. This is projected to save $500,000 in the first year and $11,300,000 in the second. But the assumption that these individuals, who are eligible (for now at least) for subsidies to buy insurance on the state's health insurance exchange (Access Health CT or AHCT), will just shift their health insurance coverage to there is baseless. When we cut the **higher** income HUSKY A parents (between 155% and 201% of FPL) two years ago, the final result was that only about 3,100 of the 18,900 adults who were cut off, or about 16%, ended up getting and keeping insurance through AHCT. While some were able to stay covered under another HUSKY category, most of the rest simply could not afford the AHCT premiums, even with their subsidies, so they never signed up or, if they did, soon dropped the coverage, and we created thousands of newly uninsured individuals as a result. (This is detailed in a recent DSS report, available at https://www.cga.ct.gov/med/council/2016/1209/20161209ATTACH_HUSKY%20A%20Transitions%20Presentation.pdf).

Since the 9,500 parents being targeted by the Governor now for elimination of HUSKY coverage have even **lower** incomes, we can expect that even fewer of them will be able to afford insurance on the exchange, so a substantially higher percentage will simply go

uninsured. In addition, when these parents lose their coverage, unfortunately, based on studies in other states, there is a very unfortunate unintended consequence: many of their children who are still eligible for Medicaid coverage nevertheless lose coverage due to confusion about the new rules.

Proposal to require prior authorization for any dental services in excess of $1000 per year for adults on Medicaid (Section 24 of HB 7040)

The Governor proposes to limit dental coverage for adults on Medicaid to $1000 per year. Dental services costing in excess of $1,000 per year are common. While the Governor says he will provide for "exceptions" where medical necessity is established through a prior authorization process, as a practical matter, this means that dentists will not provide a lot of medically necessary dental services because of the substantial administrative burdens of going through that process. Prior authorization is often a dead end for other dental services for which it is already imposed, so dentists will be disinclined to seek such authorization.

In addition, by treating any adult Medicaid patients, dentists will have to keep track of how much has been billed per Medicaid patient per year and know that, if they are seeing a Medicaid patient and discover a significant dental need, they may be put in an untenable position of committing malpractice if they do not provide the services in excess of $1000 for which payment is not available. Ceasing to take Medicaid patients entirely solves these problems for them. Many dentists are already only marginally willing to participate in Medicaid as it is, so adopting this policy and driving them from the Medicaid program would be an extremely unwise policy change.

Accordingly, while the Governor says that this will save $2,000,000 and $2,500,000, the savings will really come from dentists refusing to request, or not getting, prior authorization to provide needed dental services in excess of the $1000 annual limit or from dentists departing from the Medicaid program entirely, making access problems worse.

Proposal to end essential Medicare Part D drug co-pay frotection for Dual Eligible (Medicare/Medicaid) enrollees (Section 12 of HB 7040)

We also oppose the Governor's proposal to eliminate the protection against high copays for prescription drugs for low-income dually eligible Medicare/Medicaid individuals who must get their prescription drugs under the Medicare Part D benefit. Until July of 2014, the state covered all of those copays in excess of $15 per month. But, at the Governor's urging then, this protection was eliminated, in order to save what was projected to be only $90,000 per year. This change wreaked havoc, causing some very low income seniors and people with disabilities to go without prescribed medications for want of a copay. And the fact that they are low income and receive the federal "Low Income Subsidy" for purchasing drugs under Part D still left them with copayments that could exceed $7 per name brand drug. For individuals on several medications, the removal of the protection for copays in excess of $15 per month was an extreme

burden. We heard several stories of individuals who had to choose between filling prescriptions or paying for food or utility bills. Because of this unfortunate experience with a change designed to produce only minimal state savings, the protection was reinstated last session (although it kicked in after $17 per month instead of $15 per month).

If just two or three people end up in the hospital because of a serious medical problem which develops due to a failure to take prescribed medications, the projected savings from this cut will likely be exceeded by the additional hospital costs which could have been avoided. Let's not make the same mistake we made two years ago. Accordingly, we ask that you maintain this protection at a cost which, while *de minimus* for the overall state budget, can make the critical difference in keeping an elderly or severely disabled individual's medical condition under control.

Proposal to cut income eligibility for Medicare Savings Programs (Section 10 of HB 7040)

Under this proposal, many low-income individuals on Medicare who have their Medicare Part B premiums and, for some, their Medicare Parts A and B cost-sharing (copays and deductibles) covered by the state's Medicare Savings Programs (QMB, SLIMB and ALB) now will lose that coverage, making care unaffordable for many. It also will disqualify many low income Medicare enrollees for the Low Income Subsidy to help cover their Medicare Part D drug premiums and copay costs, since being on one of the Medicare Savings Programs automatically qualifies an individual for that federal subsidy, meaning that fewer will be able to access needed drug therapy. (Note: this is different from the Part D drug copay protection proposed to be eliminated for full Dual Eligible enrollees, discussed above.)

Support for Governor's proposal to maintain staffing levels at DSS

While there have been some improvements in several areas, DSS is still suffering from a serious shortage of processing staff, resulting in long delays in processing some applications, redeterminations and eligibility changes. We also note that there are timely application processing requirements in federal law which have been the subject of litigation against the department. Without adequate staff, DSS runs the risk of violating these requirements.

Given the agency's current inability to keep up with the amount of work it has, we should be increasing the number of DSS front line staff. At the very least, staffing levels should be maintained and any vacancies should be promptly filled, so that the recent improvements can be maintained. We therefore commend the Governor for his proposal to maintain the current staffing levels at DSS.

Concern with proposal to create Office of Health Strategy with jurisdiction to respond to any federal Medicaid cuts and propose cost-containment for Medicaid

The Governor's proposed budget summary states that, "[i]n order to coordinate efforts to react to potential health care reform changes at the federal level, the Governor is proposing the creation of a new agency, effective July 2018, to be named the Office of Health Strategy (OHS) to enhance coordination and consolidate accountability for the implementation of the state's health care reform strategies." It is proposed to be under DPH for administrative purposes and to be created through the consolidation of staff and resources from several current small offices or programs. The proposal also states that the executive director of this new office "will be responsible for developing a comprehensive and cohesive health care vision for the state, including a coordinated state cost containment strategy."

We take no position on the appropriateness of the creation of this new office. But we are concerned with the suggestion that this small group within the executive branch would coordinate the state's response to any federal changes cutting federal Medicaid reimbursements under the Affordable Care Act or through block-granting or capping the Medicaid program, and also that it would be responsible for developing a "coordinated state cost containment strategy" which includes Medicaid.

The offices proposed to be consolidated to create the OHS have very limited expertise regarding the Medicaid program. In addition, changes as fundamental as the restructuring and cutting of federal Medicaid reimbursements will require a response informed by a broad array of stakeholders, including particularly advocates for low income Medicaid enrollees. While we of course hope that neither federal block-granting nor capping ever occurs, and are actively resisting all of these proposals, should this happen, the role of developing a CT-specific response should be assigned to a group with substantial Medicaid expertise not limited to the executive branch. Such important decisions affecting hundreds of thousands of state residents and the integrity of our health safety net should be made through a publicly accountable and transparent process that is guided by public comment and input from providers, advocates and consumers with direct knowledge of how the program works, including members of the Medical Assistance Program Oversight Council.